



Claimant's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (    ) -        Work Phone: (    ) -        Carrier: \_\_\_\_\_  
Preparer's Name: \_\_\_\_\_ Preparer's Phone #: (    ) -       

**HEARING POSTPONED**

**Employee** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Employer** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Carrier** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Attorneys** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Other Parties** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TO THE PARTIES ADDRESSED:**

You are hereby notified that hearing on the above-stated case is postponed.

When the case has been reassigned for hearing, the interested parties will be duly advised of the date.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

By: \_\_\_\_\_

Code numbers furnished each employer and carrier should be inserted before mailing. Refer to Docket File No. in all correspondence about this injury.